# Cambridge Resthaven Trust Board Incorporated

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Cambridge Resthaven Trust Board Incorporated

**Premises audited:** Cambridge Resthaven

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 22 April 2015 End date: 23 April 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 78

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Cambridge Resthaven provides hospital, rest home and dementia level care for up to 92 residents. On day one of the day of the audit there were 78 residents. The service is managed by a chief executive officer and a general manager. The residents and relatives interviewed were very complimentary of the care provided.

This unannounced surveillance audit was undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, family, management, general practitioner and staff.

The service has addressed all six of the shortfalls from the previous audit relating to different aspects of resident assessment and care planning documentation, management of residents’ medication documentation, labelling and dating of stored food and servicing and calibration of medical equipment. No new areas requiring improvement have been identified during this audit.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, was accessible and is brought to the attention of residents’ (if able) and their families on admission to the facility. Residents and family members interviewed confirmed their rights were met during service delivery, staff were respectful of their needs and communication was appropriate.

The general manager is responsible for management of complaints and a complaints register was maintained.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Cambridge Resthaven Trust Board is the governing body and is responsible for the services provided at Cambridge Resthaven. Planning documents reviewed included a business plan, a mission statement, values, and philosophy.

The general manager is appropriately qualified and experienced and is supported by two clinical nurse leaders. The general manager and clinical nurse leaders are registered nurses. The clinical nurse leaders are responsible for oversight of clinical care. Registered nurse cover is provided 24 hours a day.

There was evidence that quality improvement data has been collected, collated, analysed and reported. There is an internal audit programme in place and internal audits have been completed. Corrective action plans are developed to address areas identified as requiring improvement. Risks are identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management and the validation of current annual practising certificates for health professionals who required them to practice. A registered nurse educator is employed to oversee the in-service education programme. In-service education is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards relating to aged care. Staff records reviewed provided evidence human resources processes have been followed and individual education records have been maintained.

A documented rationale for determining staffing levels and skill mix was reviewed. The minimum number of staff on duty at any one time is one registered nurse and three care givers. Clinical advice is available after hours from the clinical nurse leaders. Care staff and residents interviewed reported there was adequate staff available.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Timeframes for service delivery were met and included input from residents, families, and allied health professionals. Initial assessment, care and support is provided by competent staff, with ongoing evaluations completed by registered nurses.

There is a range of activities which are appropriate for the service users. Residents and families interviewed confirmed they were well supported to maintain interests and participation was voluntary.

The service has a documented medication management system, with staff assessed as competent to manage medications.

Resident nutritional needs are met and regular monitoring completed. Food services and storage met food safety requirements.

Required improvements from the previous audit have been met. These related to assessment information, care planning addressing all identified areas of need, wound reviews, medication administration and labelling and dating food in fridges.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

With the exception of the alterations currently being undertaken in the kitchen, there have been no alterations to the building since the last audit. The improvement identified in the last audit relating to calibration/performance verification of medical equipment has been addressed.

Documentation reviewed and observations confirmed appropriate systems are in place to ensure the residents’ physical environment is safe and facilities are fit for their purpose. A current building warrant of fitness was displayed. External areas are available for sitting and shading is provided. An appropriate call bell system is available and security systems are in place.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Both restraints and enablers were used. There are documented guidelines for the use of restraint and enablers, and managing challenging behaviours. Staff received training and demonstrated an understanding of the appropriate and safe use of restraint and enablers to maintain independence.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

There is a designated infection control co-ordinator who is responsible for ensuring monthly surveillance is completed and monitoring of infection control practices. Documentation sighted provided evidence that all staff are educated as part of on-going in-service education.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 18 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 44 | 0 | 0 | 0 | 0 | 0 |

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| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The general manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. An electronic complaints register was maintained that included verbal and written complaints and was reviewed during this audit.  The general manager advised there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board (DHB), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.  Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings. This was confirmed during interview of residents and family and review of resident meeting minutes.  Observations provided evidence that the complaint process was readily accessible and/or displayed. Review of quality/health and safety meeting minutes, staff meeting minutes and the general manager’s monthly reports provided evidence of reporting of complaints to the governing body and staff. Care staff interviewed confirmed this information is reported to them via their staff meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' electronic documentation reviewed provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the GP and family following adverse events which was recorded on the accident/incident forms and on the resident’s electronic family communication record.  Residents and family interviewed confirmed that staff communicate well with them. Residents interviewed confirmed that they are aware of the staff that are responsible for their care.  The general manager advised access to interpreter services is available if required via the local interpreting service. They also advised there are currently no residents who require interpreter services.  The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Admission agreements were reviewed and this was clearly communicated in each agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Cambridge Resthaven Trust Board is the governing body and is responsible for the services provided at Cambridge Resthaven. A business, quality and risk management plan was reviewed and included goals. Also reviewed were vision and mission statements, philosophy and scope of service provided at Cambridge Resthaven. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  The general manager (GM) is responsible for the overall management of the facility. The GM, who was appointed to their current position in September 2009, is a registered nurse with extensive health care management experience. The GM is supported by two clinical nurse leaders (CNL); one for the rest home and one for the hospital and dementia unit. The CNLs are both registered nurses and are responsible for oversight of clinical care in their respective areas. The annual practising certificates for the GM and CNL’s were reviewed and were current. There was evidence on the GM’s and CNL’s files of ongoing education.  The GM and CEO provide monthly reports to the board of directors. A selection of these and board meeting minutes were reviewed during this audit.  Cambridge Resthaven is currently certified to provide 33 hospital, 20 dementia and 29 rest home level beds. Fifty six of the beds are able to be used for either hospital or rest home level residents. There were 30 hospital, 19 dementia and 29 rest home level residents during this audit. There was one resident aged less than 65 years.  The service provider has funding contracts with the District Health Board (DHB) and Ministry of Health to provide aged related residential care (rest home, dementia and hospital), day care, residential respite, long term support - chronic health conditions services, and residential – non aged services. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A business plan and quality and risk management plan were reviewed. These are used to guide the quality programme and include goals and objectives. The quality systems, including policies and procedures, are fully implemented.  An internal audit programme is in place and internal audits completed in 2014 and 2015 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual was available that included relevant policies and procedures.  Documented values, mission statement and philosophy were reviewed. Monthly registered/enrolled nurses, health and safety/quality, staff and resident meetings are held. A selection of meeting minutes for 2014 and 2015 were reviewed and these are available for review by staff. Meeting minutes reviewed provided evidence of reporting and feedback on completion of internal audits and various clinical indicators.  A sample of the general manager’s (GM) reports to the chief executive officer (CEO) for inclusion in the CEOs reports to the board was reviewed. A sample of Trust Board meeting minutes was also reviewed. There was evidence of reporting on occupancy, staffing and human resource management, environmental and property reports, financial reporting and general comments. The GM is responsible for ensuring the organisations quality and risk management systems are maintained.  Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed, evaluated and reported. Quality improvement data reviewed, including adverse event forms, internal audits and meeting minutes provided evidence that corrective action plans were being developed, implemented, monitored and signed off as being completed.  Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they were advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.  A health and safety manual is available. There is a hazard reporting system available as well as a hazard register. Chemical safety data sheets were available that identify the potential risks for each area of service. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Registered nurses (RN) are advised of all adverse events and undertake an assessment of the resident. The RN is responsible for investigating the event as well as for documenting any corrective actions required and notifying the family. All accident and incident forms are reviewed by the clinical nurse leaders (CNLs). Neurological observations are completed as appropriate. Corrective action plans to address areas requiring improvement were documented on accident/incident form and there was evidence of monitoring of this. A weekly meeting is also held involving the CNLs, the health and safety representative and the GM to review all adverse events. The GM signs these forms off when completed. An electronic register of accidents and incidents is maintained.  Resident electronic files reviewed provided evidence of communication with family and GP. There was also evidence of this communication documented on the accident/incident form. There was also evidence of notification to family of any change in resident’s condition. This finding was confirmed during interviews of residents and family members. There is an open disclosure policy.  Staff confirmed during interview that they were made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Staff also confirmed they were completing accident / incident forms for adverse events. Policy and procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control). |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, completed orientations and competency assessments (as appropriate). Copies of annual practising certificates were reviewed for all staff that require them to practice and were current.  A registered nurse educator is employed for 24 hours a week to oversee the in-service education programme. There was evidence available indicating in-service education was provided for staff at least monthly. The education records for 2014 to 2015 were reviewed. Individual staff attendance records are maintained on an electronic register and were reviewed. These provided evidence ongoing education was provided. Competency assessment questionnaires were available and completed competencies were reviewed.  Staff are supported to complete the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers. All staff working in the dementia unit have commenced or completed the dementia specific aged care education modules.  An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.  An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The registered nurse educator advised that staff were orientated for five to ten shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.  Care staff interviewed confirmed they have completed an orientation, including competency assessments (as appropriate). |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided 24 hours a day. On call after hours registered nurse support and advice is provided by the clinical nurse leaders. The minimum amount of staff on duty is during the night and consists of one registered nurse and three caregivers. Observations during this audit confirmed adequate staff cover was provided.  Care staff interviewed reported there was adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift.  Residents and family interviewed reported staff provide them with adequate care. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Staff were observed administering medications during the lunch time medication round and followed correct procedures. Administration records were maintained. Interviews with staff and a review of staff files confirmed that only staff who had been assessed as competent were responsible for medication management. Medication trolleys and cupboards were observed to be locked.  All medicines had been prescribed by the GP using a pharmacy generated medication chart. All charts included photo identification and any allergies identified. Three monthly GP reviews were evident. Individually prescribed medications were used and a robotics system utilised. Hospital medications and rest home medications were managed separately, and stored in designated locked rooms. There was a controlled drug locked safe with log books maintained and evidence of regular weekly reconciliation sighted. Medication fridge records evidenced daily monitoring of temperature. Residents identified as self- administering medicines had been assessed as competent to do so. Specimen signatures for staff and GP’s were recorded.  Areas identified as requiring improvement at the previous audit were reviewed and have been now been met. These related to ensuring medication is documented as administered and as prescribed, and ensuring that ‘as required’ medications document indications for use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is contracted to an external agency. Residents are provided with a well-balanced diet which meets nutritional requirements. Kitchen staff confirmed that there was dietitian input into the menu. A six weekly menu is followed. Residents and family interviewed were satisfied with the meals provided and minutes of a residents meeting also confirmed this. Dietary assessments are completed on admission and special dietary requirements are highlighted and recorded on documents held in the kitchen. Individual food preference lists were sighted and any allergies identified. Kitchen staff have the required food safety qualifications. The kitchen was well stocked, clean and tidy. There was evidence of temperature monitoring and maintenance of a cleaning schedule. Required improvement relating to labelling and dating food was reviewed and is now being actioned. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents had a nursing assessment completed. They were completed within the identified timeframes and included resident centred goals.  Residents and families interviewed confirmed their involvement in the assessment process.  Clinical staff demonstrated use of a variety of assessment tools to assist in the assessment process.  Progress notes and interviews with clinical staff confirmed that assessment was an ongoing process with regular evaluations being completed by the RN.  Required improvements from the previous audit were reviewed. These related to ensuring all residents have current assessments, and all documents and alterations to documents being signed and dated. These improvements have now been made. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long-term and short-term care plans were developed and include goals identified by the resident. Care plans identified interventions that relate to all identified areas of need. This was identified at the previous audit as requiring improvement. The required improvements have now been made.  Clinical staff interviewed confirmed access to resident files and completion of daily progress notes demonstrated prescribed care was completed.  There was evidence of allied health support within the care plan process, for example, physiotherapy.  Residents observed had the necessary prescribed equipment to minimise risk and promote independence. The GP described an effective working relationship with staff, and confirmed continuity of service delivery. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The RN, GP and care staff were interviewed regarding prescribed care and care plans were sighted. Interventions were consistent with best practice. Short term care plans were developed as required, for example, for one resident who recently developed an infection.  Documentation completed daily by care staff confirmed care was being completed as prescribed.  The GP had confidence that interventions were implemented in an appropriate and timely manner.  A previous area of required improvement related to ensuring wounds were reviewed in the stated timeframe. This was reviewed and has now been addressed. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist was interviewed. Activities are facilitated five and a half days per week. Activities are planned in advance and include a variety of activities appropriate to residents’ needs.  Support is provided for residents to attend activities specific to their needs, and includes transport and one on one support as required. Residents were observed participating in the days planned activities. They were well supported and appeared to be enjoying the activities.  Participation records are maintained and residents confirmed participation was voluntary. An activities board was visible and each resident was provided with a monthly activities plan which was displayed in their room. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Files sampled included evaluations. Evaluations are conducted regularly, involved residents, family members, and multi-disciplinary team members and described the degree of achievement and progress towards meeting desired outcomes.  The RN initiated changes to the plan of care where progress was different from expected, for example, infections.  Family members confirmed a high level of satisfaction with the service supporting the resident to achieve their desired outcome. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | With the exception of the current building alterations in the kitchen, there have been no alterations to the building since the last audit.  Documentation and observations evidenced a current Building Warrant of Fitness is displayed that expires 12 May 2015.  There is a full time maintenance person on site. The maintenance person was interviewed and advised that external contractors are used for plumbing, electrical and other specialist areas. During interview the maintenance person confirmed there is a maintenance programme in place that ensures buildings; plant and equipment are maintained to an adequate standard. The improvement identified during the last audit relating to calibration of medical equipment has been addressed. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Calibration reports for medical equipment were reviewed. Current electrical safety tags were viewed on electrical items.  Observations of the facility provided evidence of safe storage of medical equipment. Corridors are wide enough to allow residents to safely pass each other; safety rails are secure and are appropriately located.  External areas are available for residents and these are maintained to an adequate standard and are appropriate to the resident groups. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring a safe area is available for recreation or evacuation purposes.  Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.  Residents confirmed they know the processes to follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The clinical nurse educator is the infection control co-ordinator and confirmed a surveillance programme was maintained. Surveillance data was sighted and included infection details related to files sampled. Monthly analysis was completed and reported at monthly staff meetings. The infection control surveillance is appropriate to the service and support from an external consultancy firm also provides quarterly benchmarking. There was an outbreak within the past twelve months. Support was provided by DHB specialist staff and records sighted confirm it was well managed and contained. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The use of restraints and enablers are used appropriately. Care plans included alternative interventions to restraint. Monitoring was completed when restraint and enablers were in use. Staff have been provided with education related to the safe management of restraint and managing behaviours of concern, and staff identified that enablers are required to be voluntary and the least restrictive option. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| --- |
| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| No data to display |

End of the report.